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Debate: Extraordinary means and the sanctity of life

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Editor's note

Ms Kuhse argues against the doctrine of 'the sanctity of life', against the application of acts and omissions doctrine in medical practice, and against the common assumption that there is a crucial moral difference between intentionally discontinuing ordinary medical treatment and intentionally discontinuing extra-ordinary medical treatment. Intentional acts or omissions which shorten life are in practice and must in theory be justified or rejected on the basis of the quality of life concerned, she argues. Such quality of life distinctions are needed in practice but they are logically incompatible with the doctrine of the sanctity of life; and the ordinary/extraordinary means distinction cannot circumvent this incompatibility.

Father Hughes in his commentary rejects Ms Kuhse's extreme interpretation of sanctity of life doctrine. He argues that the distinction between acts and omissions is relevant to medical practice and distinguishes between two different senses of 'omission' to support this. He finds Ms Kuhse's reliance on quality of life excessively reductionist and argues that her position seems to commit her to denying any moral difference between intending a death by withholding extraordinary treatment and intending a death by administering a lethal injection. That there is an important moral distinction here is a crucial intuition which supporters of the traditional view wish to maintain, even though 'the difficulty . . . is to discover a philosophical means to support it'. While sanctity of life doctrines need development, they express 'a healthy presumption in favour of trying to preserve it'. In a final response Ms Kuhse replies to her commentator.

Readers' attention is drawn also to the review by Professor Robin Downie on page 96 of a group of three papers entitled Prolongation of Life *published by the Roman Catholic Linacre Centre.*

Many discussions within medical ethics, explicitly or implicitly, appeal to and pivot on the 'sanctity-of-life' doctrine. Yet the really critical issues in medicine are often hidden by 'the hulking darkness of that concept'. Even those who disregard the clearly religious connotations (1) of the concept often employ it to argue that wherever there is innocent human life, nothing must count against it; innocent life must never be taken – especially not by doctors who have rejected the taking of human life since the fifth century BC when physicians first took the Oath of Hippocrates and swore to 'give no deadly medicine to anyone if asked, nor suggest any such counsel'. But if a travesty of life has irretrievably lost all that seems to make human life valuable, then even the most ardent supporter of the doctrine may feel that life ought not to be prolonged unnecessarily. Faced with an absolute prohibition against the intentional termination of life, proponents of the 'sanctity-of-life' doctrine argue that it is then permissible to withhold or withdraw 'extraordinary' or 'disproportionate' means of life support. Failure to provide 'ordinary' care is generally seen as the intentional termination of life, or passive euthanasia. The cessation of 'extraordinary' treatment, on the other hand, is interpreted differently: it is regarded as the decision 'to provide the most appropriate treatment for that patient at that time' (2).

The rationale underlying the distinction between ordinary and extraordinary means is thus the idea that there is a crucial moral difference between intentionally discontinuing ordinary treatment and intentionally discontinuing extraordinary treatment. This belief is very common; it is implied by the 1973 policy statement of the American Medical Association (3), is supported by the philosopher Bonnie Steinbock (4) and has most recently been reconfirmed by Pope John Paul II in the Vatican's '*Declaration on Euthanasia*' (5). However, I believe that it can be shown to portray either confused thinking or a point of view unrelated to the interests of individual patients.

'Heroic' efforts and modern medical technology

Sophisticated modern medical technology is achieving a continuously increasing control over our lives, and even if unable ultimately to conquer death, it has a lot to say about the conditions and time of its occurrence. With this, an old question is raised with renewed urgency: must human life, regardless of its quality, always be preserved? Is it the physician's duty to sustain indefinitely the life of an irreversibly brain-damaged person by way of artificial respiration and intravenous feeding? Must the physician engage in 'heroic' efforts, that is, employ all of modern medicine's devices to add

another few weeks, days, or even hours to the life of a terminally ill and suffering cancer victim, or is it permissible to discontinue treatment? Must active treatment be instigated with regard to babies born so defective that their future promises little more than continuous suffering or mere vegetative existence?

These questions are not new but they are, today, posed with relentless clarity and urgency: Given that we *can* sustain lives such as the above, *ought* such lives to be sustained – and if not, why not? Most of us would want to hold that there are, or should be, limits to the physician's duty to prolong life – but it is difficult to see how such limits can be incorporated within a 'sanctity-of-life' ethic that absolutely prohibits the intentional termination of life and that sees all human life, regardless of its type or quality, as of infinite and intrinsic worth. Here the 'can' would seem to imply the 'ought'. Given that a human life can be prolonged by medical intervention, it ought to be prolonged – and it does not matter whether the life thus prolonged is conscious, unconscious, painfree or irrelievably filled with suffering.

When speaking of the 'sanctity-of-life' ethic, I am not suggesting that the prohibition against the taking of human life has always been held in an absolute form, for this would imply total pacifism, exclude capital punishment, sacrificial heroism and killing in self-defence, practices which are not always condemned by supporters of the doctrine. But in the realm of medical practice, the 'sanctity-of-life' ethic has ruled supreme for a very long time (6). Here the intentional termination of life is not only absolutely prohibited, but the traditional component of deontological ethics, the acts and omissions doctrine, has no application in the doctor/patient relationship. Although medical applications of the distinction between ordinary and extraordinary means are sometimes misinterpreted as applications of the distinction between acts and omissions (7), it is widely accepted that it is no excuse for a doctor to say that he did not kill his patient but 'merely' let him die by withholding life-saving treatment. Both medical ethics and the law impose a duty on the doctor to care for his patient, which puts the doctor *vis-à-vis* his patient in a very different situation from that of an ordinary citizen who omits to save the life of a stranger. Indeed, the Vatican's *Declaration on Euthanasia* defines 'mercy-killing' as 'an act or an omission which of itself or by intention causes death' (8).

This is an extension of the rule 'Do not kill' which, for doctors, now reads: 'Do not kill and do not let die', *ie*, the absolute prohibition against shortening the patient's life – even for compassionate reasons – applies to both acts *and* omissions. Letting die, like killing, is absolutely prohibited, for 'letting die', as understood here, always implies a counterfactual conditional of the type: If D did Y, then X would not happen. For example, if the physician were to give a life-prolonging injection, the patient would not die. Both killing and letting die thus constitute the 'intentional termination of the life of one human being by another – mercy killing' and this is, according to the American Medical Association, 'contrary to that for which the medical profession stands' (3). Euthanasia, whether active or passive, is thus absolutely prohibited.

If the 'sanctity-of-life' doctrine as it underlies the practice of medicine is absolute in this sense, there is another sense in which it is absolute as well: it makes no distinction between different types or qualities of human life – all life is of equal and intrinsic worth. Chief Rabbi Jakobovits captures the general thrust of the Judaeo-Christian tradition when he comments: 'The basic reasoning behind the firm opposition of Judaism to any form of euthanasia proper is the attribution of *infinite* value to every human life. Since infinity is, by definition, indivisible, it follows that every fraction of life, however small, remains equally infinite so that it makes morally no difference whether one shortens life by seventy years or by only a few hours, or whether the victim of murder was young and robust or aged and physically or mentally debilitated' (9).

Similarly, the Roman Catholic Church's position: 'It is necessary to state firmly one more that nothing and no one can in any way permit the killing of an innocent human being, whether a foetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying' (10).

On this view, not only does the distinction between acts and omissions not apply, but it is also irrelevant whether or not it is in the patient's interest to have his life prolonged. As one physician puts it: 'The patient entrusts his life to his doctor, and it is the doctor's duty to sustain it as long as possible. There should be no suggestion that it is possible for the doctor to do otherwise, even if it were decided that the patient were "better off dead" ' (11).

Similarly, another physician: 'It is not the privilege of any doctor to decide that he should shorten life. The preservation of life must be the sole principle guiding medical practice, including treatment of the hopeless cancer patient. This principle cannot be tampered with or interpreted loosely' (12).

This attitude, whilst it may strike many as cruel and impervious to the interests of the patient, is consistent with the 'sanctity-of-life' principle. It is, however, not in accordance with generally accepted practice. Each year, thousands of defective infants are 'allowed to die' (13), terminally ill patients do not have their lives prolonged by all possible means (14), and the life-support of irreversibly comatose patients is withdrawn in the clear knowledge that death will, in most cases, follow within minutes (15).

But if lives such as these could be prolonged and a

decision is taken against prolonging them, we appear to be confronted with the practice of passive euthanasia. However, if these practices are forms of euthanasia, then one would want to know how they can be incorporated in a sanctity-of-life ethic that absolutely forbids the intentional 'hastening of the hour of death' (16). The question is especially baffling if, as I have suggested, the acts and omissions doctrine is out of place in the doctor/patient relationship. For then what we have is a practice morally equivalent to active euthanasia.

An answer to this question has traditionally been given in terms of the distinction between 'ordinary' and 'extraordinary' means of treatment. Whilst failure to employ 'ordinary' means is generally identified with the intentional termination of life, failure to provide 'extraordinary' means is given a different status. The Roman Catholic Church sees it as 'a wish to avoid the application of a medical procedure disproportionate to the results that can be expected . . .' (16).

Judaism, too, supports the distinction between ordinary and extraordinary or 'artificial' means:

> We, too, would make a fundamental distinction between any deliberate hastening of death, whether with or without the patient's consent, on the one hand, and the withdrawl of *artificial* means to sustain a lingering life in its terminal stages on the other, particularly when the recourse to such 'heroic' methods would serve only to prolong the patient's agony. However, the sanction to discontinue treatment would not include the withdrawal of food or other necessities of life (17).

And, in 1973, the distinction between ordinary and extraordinary means of life-support moved from the religious into the secular realm, when it was employed in the *AMA's* policy statement. After rejecting the intentional termination of life as 'contrary to that for which the medical profession stands,' the statement continues:

> The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that death is imminent is the decision of the patient and/or his immediate family (3).

If the above positions, Roman Catholic, Judaic and medical, are not to be blatantly self-contradictory, they must hold that the termination of extraordinary care is not the intentional or deliberate termination of life.

What, then, constitutes 'extraordinary' treatment? The language of extraordinary means has a long history – especially in the Roman Catholic Church – where the employment of ordinary means has always been seen as obligatory, whereas the employment of extraordinary means was generally regarded as optional (18). As Pope Pius XII phrased it:

> . . . normally one is held to use only ordinary means – according to circumstances of persons, places, times and culture - that is to say, means that do not involve a grave burden for oneself or another. A more strict obligation would be too burdensome for most men and women and would render the attainment of the higher, more important good too difficult . . . (19).

Subsequent to this, the following standard definition was adopted:

> Ordinary means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience . . . Extraordinary means of preserving life . . . mean all medicines, treatments, and operations, which cannot be obtained without excessive expense, pain or other inconvenience, or which, if used, would not offer a reasonable hope of benefit (20).

However, a long history does not guarantee clarity and the Catholic Church has noted that even though the extraordinary means criterion 'as a principle still holds good', a reformulation is indicated 'by reason of the imprecision of the term and the rapid progress made in the treatment of sickness'. 'Thus', the recent Papal statement continues:

> . . . some people prefer to speak of 'proportionate and 'disproportionate' means. In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources (21).

In other words, a major factor in determining whether a means is optional, *ie*, extraordinary or disproportionate, is the 'state of the sick person' and 'the result that can be expected'. A means can thus be *either* extraordinary *or* ordinary, depending on the condition of the patient, and the adjective 'optional' ('extraordinary', 'disproportionate', 'artificial') refers not simply to the treatment considered on its own, but to the treatment considered in relation to the condition of the patient. As Bonnie Steinbock puts it: 'The concept is flexible, and what might be considered "extraordinary" in one situation might be ordinary in another' (22). While the use of a respirator to sustain a patient through a severe but temporary respiratory ailment would be regarded as ordinary, its 'use to sustain the life of a severely brain-damaged person in an irreversible coma would be considered extraordinary' (22).

But here the term 'extraordinary' has been so relativised to the condition of the patient that it is precisely the condition of the patient that changes an ordinary means into an extraordinary one. The respirator becomes an extraordinary means because the patient's condition is extraordinary, *ie*, the patient's condition is unusual in the sense that in this particular situation, and contrary to the absolute tenets of the 'sanctity-of-life' doctrine, the prolongation of the patient's life has become optional. But if the kind of life that could be prolonged by medical intervention is allowed to be relevant in the decision as to whether or not a certain means will be employed, then we are implicitly moving from a 'sanctity-of-life' ethic to a 'quality-of-life' ethic.

Such a move is also implied in Bishop Lawrence Casey's support for the decision to remove Karen Quinlan from the respirator because she 'has no reasonable hope of recovery from her comatose state by the use of any available medical procedures. The continuance of mechanical (cardiorespiratory) supportive measures to sustain continuation of her body functions and her life constitute extraordinary means of treatment' (23). Mechanical supportive measures are extraordinary because, while they sustain Karen's life, they sustain it only in a comatose state (24). It is the comatose state which is determinant, not the inherent 'extraordinariness' of the means, nor the fact that Karen 'has no reasonable hope of recovery'. If the recovery criterion were decisive, then also the continued use of 'iron-lungs' for polio-victims and the continued injection of insulin for diabetics would be extraordinary and hence optional because they could not lead to recovery from the state of paralysis, nor cure the diabetic condition.

However, all three forms of treatment have one thing in common: their continued application will prolong the patient's life. If it is thus permissible to discontinue treatment in the one case but not in the other two, a defender of this view must point to a morally relevant difference that distinguishes these cases. It is not, as we have seen, the distinction between ordinary and extraordinary *means*, considered simply as means, and it cannot be the distinction between the intentional and the non-intentional termination of life. Because if we accept (as most of us, even non-Catholics, would) that life can be terminated intentionally by either 'an action or an omission which of itself or by intention causes death' (25), then withholding of insulin treatment or 'pulling the plug' of an iron lung would be examples of the intentional termination of life. But if 'pulling the plug' of a polio victim's iron lung is the intentional termination of life, then – surely – 'pulling the plug' of Karen Quinlan's artificial respirator is too. (Suppose she had died as a result).

If there is a morally relevant difference between such cases, it must lie elsewhere. And so it does. It lies in the different qualities or types of life preserved by continued medical support. But quality-of-life criteria cannot be incorporated into a 'sanctity-of-life' ethic that regards all human life, irrespective of its type or quality, as of the same intrinsic worth. According to the 'sanctity-of-life' doctrine, comatose human life has the same 'sanctity' as the life of a conscious or self-conscious human being. Hence this doctrine is incompatible with the way the distinction between ordinary and extraordinary means is drawn by Bishop Lawrence Casey and as it is presupposed by the recent Papal *Declaration on Euthanasia.*

The undefined use of the term 'human life' avoids a necessary task: it does not say what it is that gives value to human life; it does not say what principles should serve as possible justification for the termination or continuation of human life. While I have no way of refuting someone who holds that being physiologically alive, even though unconscious, is intrinsically valuable, I can refute all those who want to combine this position with a limited duty of life-preservation in 'extraordinary' cases. The two positions are incompatible because the moral relevance of the adjective 'extraordinary', in this and many other cases, must rest on quality-of-life considerations, the moral relevance of which is being denied by the 'sanctity-of-life' doctrine.

The important point is this: we are faced not merely with a theoretical confusion, of interest only to philosophers and moral theologians, but with a misleading doctrine that has indefensible consequences in practice as well. Much of the current medical literature shows that there has been an implicit shift to quality-of-life standards (26), and sociological studies indicate how certain qualitative factors enter into medical decision-making in life and death cases (27). But from an ethical perspective the quality-of-life question is not adequately treated until and unless one gives morally relevant reasons as to why a certain quality or qualities *should* be decisive in terminating or continuing life-prolonging treatment (28). In practice this means that the medical profession is, in the absence of such standards, faced with an anarchy of values and meaning.

Thus doctors have applied (29), but – according to Steinbock – misinterpreted (30), the 'extraordinary means' criterion in situations like the famous Johns Hopkins case, where a Down's syndrome child requiring routine surgery for an intestinal obstruction was 'allowed to die' by dehydration and starvation over a 15-day period on the grounds that surgery would have been an 'extraordinary' procedure. In cases like this, surgery can be withheld not because the treatment is, in any way, 'extraordinary'. but because the concept 'extraordinary' is 'extremely flexible'. If a child not afflicted with Down's syndrome is born with an intestinal obstruction, surgery to remove the obstruction is an 'ordinary' procedure. When a

mongoloid child has such an obstruction, surgery becomes an 'extraordinary' procedure. Why? Not because the nature of the operation has changed, but because the child is a mongoloid. A mongoloid child's life is given a different value from that of a normal infant. The 'extraordinary means' criterion thus masks a quality-of-life judgment which may well require – but does not receive – further justification (why is it in a mongoloid infant's interest to die?) (31). Furthermore, if euthanasia for mongoloid infants can be justified, why then only for those with an intestional obstruction requiring a simple operation? The answer is that in the latter case, but not in the former, the 'extraordinary means' criterion can be invoked to mask a quality-of-life decision that is incommensurable with a 'sanctity-of-life' ethic.

By presenting quality-of-life decisions as an almost technical question, namely as one concerning 'means' which may or may not be optional, substantive moral issues are evaded. One of these is the question of what it is that we value when making quality-of-life decisions. If we decide that 'certain heroic intervention is not worthwhile' (32), *ie* that the value of an individual's life is insufficient to warrant continuation of life-prolonging efforts, this requires a clear assessment of the locus of that value and if it derives from different sources, their relative weights. As long as such substantive criteria are not made explicit in medical decision-making, as long as we rely on the extreme flexibility of the concept of 'extraordinary means' to make a sanctity-of-life ethic superficially credible, we will engage in muddled practice. Doctors will let infants die by withholding 'extraordinary' or 'disproportionate' treatment on the basis 'that prognosis for *meaningful* life [is] extremely poor...' (33), without, however, being able to provide substantive criteria as to what constitutes a 'meaningful life'; they will also resuscitate six times the 68-year-old doctor suffering from terminal cancer (34) on the basis that resuscitation is now an 'ordinary' procedure in the modern hospital setting. They will do so without being able to say what value or values they are trying to serve, other than to act in accordance with a 'sanctity-of-life' ethic that is impervious to the interests of the patient.

The point is that in our age of sophisticated medical technology death is often not 'imminent in spite of the means used' (35). Death can often, quite literally, be kept waiting by the bed or the machine. It is only when supportive measures are discontinued that death becomes imminent. Discontinuing such measures is, unavoidably, a 'hastening of the hour of death' (35). It also, unavoidably, requires the shouldering of moral responsibility for the death of the patient.

This brings me to my second point: the extraordinary means criterion hides this responsibility under the mantle of its means-related language. While it may well be true that the doctor has, in certain circumstances, 'no reason to reproach himself with failing to help the person in danger' (35), substantive criteria must be provided to tell us what these circumstances are. In all those cases where death is not imminent in spite of the means used, the physician is responsible for the death of the patient when he decides not to operate, to discontinue treatment, or to turn off the artificial respirator. As Robert S Morison puts it:

> Squirm as we may to avoid the inevitable, it seems time to admit to ourselves that there is simply no hiding place and that we must shoulder the responsibility of deciding to act in such a way as to hasten the declining trajectories of some lives, while doing our best to slow down the decline of others. And we have to do this on the basis of some judgment on the quality of lives in question (36).

When the Nuer, an East African tribe, saw a need to do away with defective infants, they did it by classifying these defective infants as 'hippopotamusses', mistakenly born to human parents. These infants were put into the river – their natural habitat. This was not killing Nuer infants, it was doing what was appropriate for young hippopotamusses; and Nuer morality, prohibiting the taking of tribal life, could emerge unscathed (37).

When we allow defective infants to die by classifying as 'extraordinary' the means used to keep them alive, we are resorting to an equally spurious device in order to preserve unscathed our sanctity-of-life ethic. If we want to go beyond definitional ploys, we must accept responsibility for our life-and-death decisions, we must drop the traditional sanctity-of-life ethic and embrace a quality-of-life ethic instead.

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(13) See *New York Times* 1974 June 16: Part IV: 7, as cited by Singer P. *Practical ethics.* Cambridge: Cambridge University Press, 1979; 149 and 229.
(14) See Rachels J. Euthanasia, killing and letting die. In: *Ethical issues relating to life and death.* New York and Oxford: Oxford University Press, 1979; 150, on the practice of 'no coding'.
(15) See *Melbourne Herald* 1979 November 29, reporting on the death of a squash champion who had suffered severe brain damage following cardiac arrests. 'The machine, in the Royal Adelaide Hospital's intensive care unit, was switched off just after midnight and Torsam Khan, 27, was dead within 10 minutes'.
(16) See reference (5): 11.
(17) See reference (9): 6 – italics in original.
(18) Beauchamp T L, Childress J F. *Principles in biomedical ethics.* New York: Oxford University Press, 1979; 117–126.
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(33) Duff R S, Campbell A G M. Moral and ethical dilemmas in the special care nursery. See reference (26): 890 (italics added).
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Commentary

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It would be difficult to read Helga Kuhse's paper and remain convinced that all was well with the arguments in medical ethics about the preservation of life, or that the guidelines for medical practice were perfectly clear. Her case for saying that there are both philosophical difficulties and practical uncertainties is surely unanswerable. Upon closer inspection, however, it becomes less obvious precisely which points she has established, which a more traditional moralist would be concerned to dispute. Ms Kuhse makes several points: one is that there is a serious inconsistency in the traditional view of the sanctity of life; the second is that the distinction between actions and omissions has no application in the traditional view; and the third concerns a more positive proposal to replace the traditional doctrine about the sanctity of life by a fully explicit appeal to the quality of life. I should like to reply, as it were on behalf of the traditional position, on each of these points, and to make some remarks on precisely how they are connected to one another.

Helga Kuhse argues that it is inconsistent to hold both the 'sanctity of life doctrine' and the view that there is an important distinction to be drawn between ordinary and extraordinary means of preserving life. Now, it certainly is inconsistent to hold both:

a) that one must never intentionally kill, shorten life, or allow someone to die, and
b) that one is not obliged to take extraordinary means to preserve someone's life,
c) just if it is also held that the prohibition on allowing someone to die obliges one to take all possible means to keep him alive.

The charge of inconsistency crucially depends on showing that the 'sanctity of life doctrine' must